CHIROPRACTIC NEW PATIENT

Springfield Lakes CHIROPRACTIC &Massage

Date: _____

Personal Details

Title: Dr _____

Full Name

Address: _____

_____ Post Code _____

Telephone: (Home) _____ (Mobile)_____

(Work) _____ (Email) _____

Date of Birth_____ Number of Children:____Partners Name: _____

Occupation_____ Health Fund: _____

I am happy to receive Reminders Via- ☐ SMS ☐ Email ☐ Both

Referral Details

Who can we thank for referring you to us:

Family/Friend (name): _____

☐ Social Media ☐ Google ☐ Signage ☐ Yellow pages

☐ Health Fund ☐ Health Care Practitioners ☐ Wellness Workshop ☐ Voucher

Accidents or Injuries

List any accidents or injuries: Date Date

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Your Medical Doctor is: _____ Clinic Name/Suburb: _____

Health Details

List any medications currently taken: ☐ Pain Killer ☐ Muscle Relaxants Anti- Inflammatory

☐ Birth Control ☐ Blood Pressure ☐ Vitamins

Please list any other: _____

List any Operations: Date Date

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Do you suffer from any of the following:

☐ Headaches	☐ Shortness of Breath	☐ Numbness in Arms/Hands
☐ Neck Pain/ Stiffness	☐ Loss of Smell	☐ Cold Hands/Feet
☐ Back Pain/ Stiffness	☐ Period Pain	☐ Cold Sweats
☐ Fatigue	☐ Constipation/ Diarrhoea	☐ Dizziness
☐ Depression	☐ Fainting	☐ Sleeping difficulty
☐ Fever	☐ Chest pain	☐ Can't fight infections

What is the reason you have consulted this practice: _____

What was the cause: _____

When did the problem commence: _____

Is the problem: ☐ Getting Worse ☐ Staying the Same ☐ Getting Better

Have you had a similar case before: ◯ Yes ◯ No

Does it interfere with: ☐ Sport ☐ Home ☐ Sleep ☐ Recreation ☐ Work

Have you previously seen a Chiropractor:

◯ Yes (Who) _____ Date: _____ ◯ No

If yes, was it for a similar condition: ◯ Yes ◯ No

Did it help: ◯ Not at all ◯ Some what ◯ Mostly ◯ Complete Resolution

Have you seen any other health professional about this problem:

◯ Yes (Who) _____ Date: _____ ◯ No

Did it help: ◯ Not at all ◯ Some what ◯ Mostly ◯ Complete Resolution

Exercise/ SportsActivities

Please outline any exercises/sports or activities that you are currently participating:

_____

_____

_____

Is there anything else you would like to tell us:

_____

_____

_____

Springfield Lakes Chiropractic & Massage
Clinic Consent Form

Chiropractic Care, when performed by a qualified Chiropractor has been found to be both effective and safe form of care for many health conditions.

There are, however, risks associated with any treatment no matter how small, that you need to be informed of and we ask that you read the following carefully:

- I understand there are very minimal risks resulting from treatment, such as but not limited to; muscle and joint soreness, sprain, muscle strain, disc injury, nerve irritation or damage.

- I understand in extremely rare cases, some treatments to the neck may result in injury to blood vessels and give rise to stroke or stroke like symptoms.

- I understand that results are not guaranteed and that consent can be withdrawn at any time.

- I give consent, by signing below, to cover the entire course of treatment for my presenting complaint(s), and for any other future condition(s) for which I seek treatment from the below named Chiropractor and any of the registered Chiropractors practicing at Springfield Lakes Chiropractic.

- I have read, or have had read to me the above consent and I have also had an opportunity to ask questions about this content.

- I give consent for my Chiropractor to consult and transfer relevant Clinical information to other Chiropractors in the Clinic and other Therapists I may see from time to time.

- I am aware of Springfield Lakes Chiropractic and Massage's Cancellation policy. I must give 24 hours notice of any appointment Cancellation or I shall be charged in full for the visit charge.

_____ _____

Patient's Signature (Parent or Guardian) Chiropractor's Signature

_____ _____

Patient's Name Chiropractor's Name

_____ _____

Date Date